DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY
WHERE PEOPLE GROW

Independent Guidance and Handbook

HPC and other Non-Day Services

Courtesy of:

Sarah Hess, Provider Liaison

Ph: 937-346-0740

Email: shess@clarkdd.org

DEVELOPMENTAL DISABILITIES
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Common Issues for HPC/Non-ADS Providers

1. **Are services matching the PCP?**
    a. Johnny's plan says he wants to explore his community, try new things, and meet new people, but aside from attending a day program, he only leaves home once a week for grocery shopping and the occasional cup of coffee from a drive-thru window. This doesn't match the plan and doesn't support achieving his outcome.
    b. Refusals-if a person is refusing outcomes or activities or the frequency of them that is in the plan, these need documented and what is being done to address this-prompts/encouragement/reminders, notifying the team, talking to the person about why (do they even want that outcome, is it too often to meet their current capability, etc.) and make the team aware of needed changes to the plan if applicable or needed changes to the approach. An example of changing our approach is to ask "what's the first step in getting ready to mop," rather than to tell the person "you need to get the bucket."
2. **Are services being done in the community? Is there community engagement?**
    a. Johnny's current activity is not community engagement. He does not have the opportunity to ENGAGE with anyone else in the community which could lend itself to establishing relationships and connections. There are a number of ways to create these opportunities based on Johnny's interests, such as through volunteering, participating in community classes and activities offered by parks, master gardeners etc. There are social clubs for walkers and hikers, board game enthusiasts among many other things in our community and others.
3. **Is there evidence of opportunities for individual choice?**
    a. Every day the schedule is the same, Johnny comes home from his day program, eats a snack and watches TV until dinner time. He takes his medications, bathes and watches westerns and old tv shows until bed time. This doesn't reflect choices of the individuals or offer choices on the schedule. While he chooses his TV shows, he doesn't get to choose other activities for his day. Examples of ways to show opportunities for choice:
        i. Talk with Johnny about his interests and plan activities and events for next month or next quarter-that. LOTS of local events are publicized on local TV. If Johnny has a roommate or two, include them. Have a weekly "meeting" to talk about ideas or instigate a dinner conversation about fun things to do.
        ii. Suzie wants to increase her exercise and loves skating, once or twice a month we go to a skating rink and Johnny goes, too because it sounded fun and he likes it, too.

4. **Trainings**
    a. Whether you are an agency employee or an independent provider, you are required to have trainings every year. These can vary between service types.
    b. Make sure all individual specific training was done PRIOR to working with the person(s)
    c. Make sure you have record of all of these trainings
5. **Check out the Handbook** (Agency or Independent), the rules for your services, and the Compliance Tool and Required Documents sheet from DODD's website that reviewers use when reviewing Agencies. This can be found on the Compliance page (under Support for Providers) then go to Compliance Tools on the left-hand side of the page. Search for "Independent compliance tool" and "Independent required documents" to help you. See screen shot guidance.
6. **Finances-**Those who have access to the funds should not be the ones reconciling the funds each month. If you are an independent provider, the SSA for that person is often the choice for reconciling the account.
    a. Ensure that if you work with personal funds, you are trained on personal funds and that the training meets the rule requirements. 5123:2-2-07 Personal funds of the individual
7. **MUI/UI-** Make sure you have record of each incident, record of reporting in a timely manner required by rule, and record of to whom notifications were made.
    a. Have a Monthly UI log tracking system with all required information (see rule, and see templates offered by DDCC and DODD)
    b. Have specific and measurable plan of correction to address the risks of reoccurrence.
    c. Make you are reviewing the log monthly and identifying trends and patterns (sign and date per each review)
    d. Send copies quarterly to DDCC by email to MUIreport@clarkdd.org or Fax: 937-328-4575
    e. Complete annual MUI report. Contact shess@clarkdd.org with any questions on UI/MUI reporting and tracking.
8. **Documentation**
    a. Make sure you're documenting the services you are designated to provide in the plan
    b. Make sure you include all required elements on your documentation sheet. These can vary by service and can be found in each service rule (most often in section E of the rule).
    c. For example, the HPC rule 5123-9-30 section E says:
    (E) Documentation of services
    Service documentation for homemaker/personal care shall include each of the following to validate payment for Medicaid services:

(1) Type of service.
(2) Date of service.
(3) Place of service.
(4) Name of individual receiving service.
(5) Medicaid identification number of individual receiving service.
(6) Name of provider.
(7) Provider identifier/contract number.
(8) Written or electronic signature of the person delivering the service or initials of the person delivering the service if a signature and corresponding initials are on file with the provider.
(9) Group size in which the service was provided.
(10) Description and details of the services delivered that directly relate to the services specified in the approved individual service plan as the services to be provided.
(11) Number of units of the delivered service or continuous amount of uninterrupted time during which the service was provided.
(12) Times the delivered service started and stopped.

9. **Transportation-**Don't forget to document # of miles and destination points.

FOR FURTHER ASSISTANCE CONTACT:

Sarah Hess, Provider Liaison

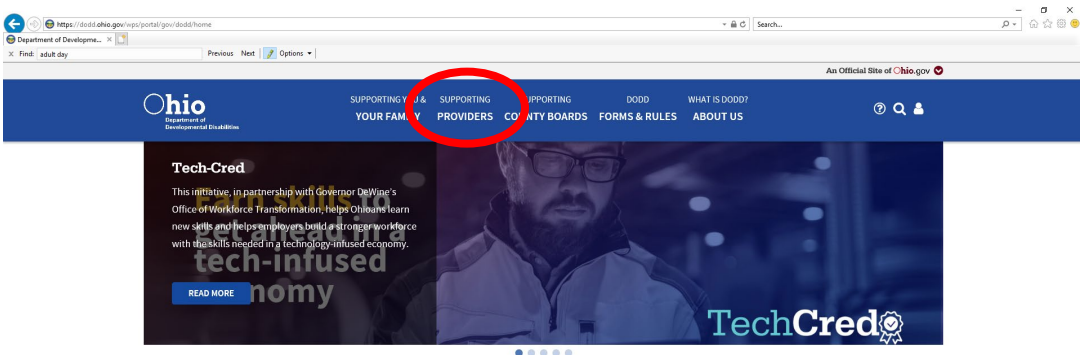
Ph: 937-346-0740

Email: shess@clarkdd.org

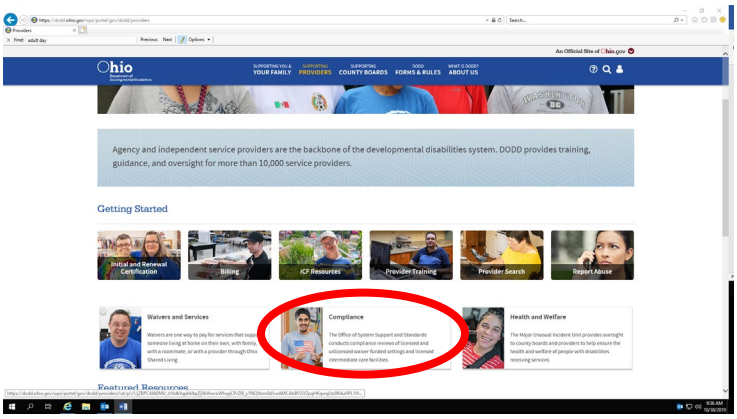
How to Find Compliance Tools

Independent Providers

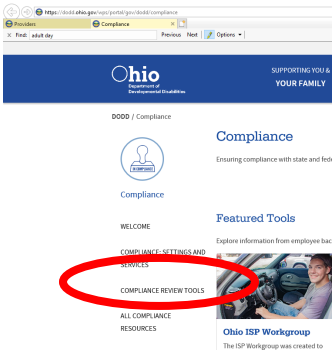
1. Go to dodd.ohio.gov
2. Click “Supporting Providers”



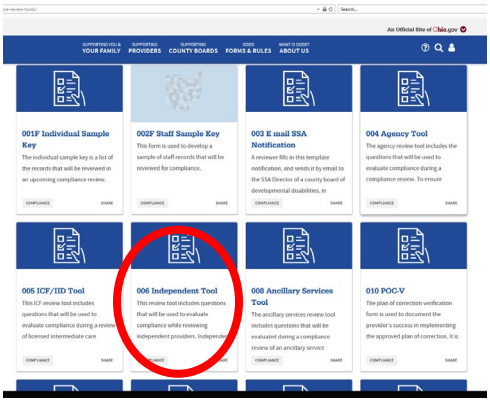
3. Click Compliance (May need to scroll down some)

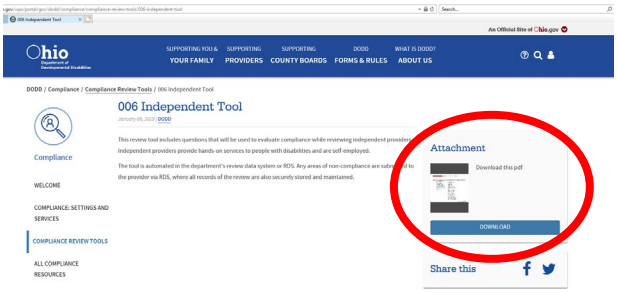


4. Click Compliance Review Tools (left-hand side)

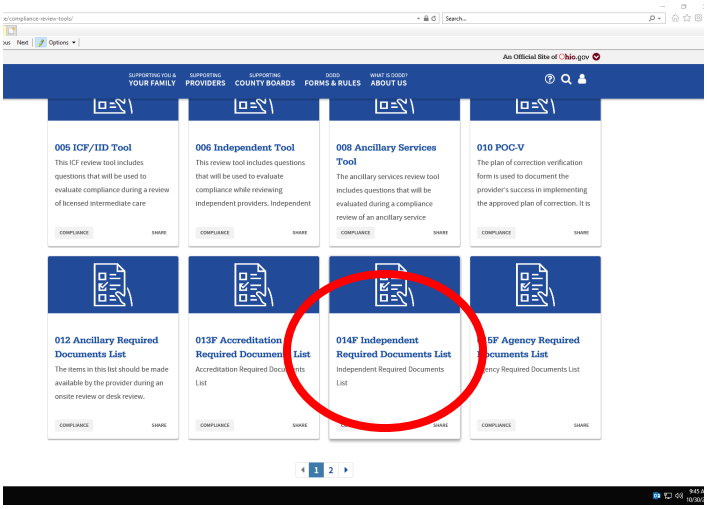


5. Select “006 Independent Tool” and “Download”





6. Back to the Compliance Review Tools page, scroll down and select “014F Independent Required Documents List” and download as above.



*Today's Community Experience*_____
Check the box that applies to today's community based Experience.

Did not seem to like the experience. Refused to engage/have fun and wanted to leave right away.	Minimal participation and enjoyment. Engaged briefly and at least tried to be involved.	Engaged and seemed to like the experience, at least for a minimal limited time and seemed somewhat interested in today's experience.	Clearly enjoyed today's experience or at least was very interested in observing or "feeling it out". Seems like they may want to return.	Actively participated and clearly enjoyed the experience. Showed emerging skills to engage. Clear body language showing interest in today's experience.	Actively and totally engaged in today's experience. Clearly this was a great match. Need to return soon to build on the great things that happened.
Struck Out ☐	**Walked** ☐	Base Hit ☐	Double ☐	**Triple** ☐	**Home Run** ☐

Completed by_____
Date_____

INTEGRATION DOCUMENTATION

Name:	Month & Year:	Type of Service:
Medicaid #:	Provider:	Provider #:

Outcome:	Action Steps & Frequency/Duration

Date	Location	What did you do and who did you meet?	Integration value	Initials

Barriers or Recommendations**:**	Next Steps:

Staff Signature &Initials	Date & Supervisor Initial

Additional Notes:

INTEGRATION DOCUMENTATION

Name_____
Date_____

Where did you go?
Who did you go with?
What did you do?
Who did you meet?
What did you talk about?
Did you like what you did?
Did your staff help you? What did they do?
Do you want to do it again?
What would you like to do next?
When do you want to do it?

Additional Notes:

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Learning Skill: Learning Log FOR

DATE	What did the person ? What, when, where, how long, etc.?	Who was there? (Names of staff, friends, others, etc.)	What did you learn about what worked well? What did the person like about the activity? What needs to stay the same?	What did you learn about what didn't work well? What did the person not like about the activity? What needs to be different?

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Learning Skill: 4+1 FOR

WHAT DID YOU TRY?	**WHAT DID YOU LEARN?**	**WHAT ARE YOU PLEASED ABOUT?**	**WHAT ARE YOU CONCERNED ABOUT?**
What did you do?	**What did you learn from your efforts?**	**What did you like about what your tried?**	**What challenges did you encounter?**
When did you do it?		**What went \well?**	**What didn't you like about what you tried?**
Who else was there		**What worked well for you?**	**What didn't work for you?**
Given your learning, what will you do next?			

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PERSON-CENTERED PLAN
Learning Skill: Next Steps FOR

What would you like to do?	Who will do it and who will help?	By When?

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Matching Interests FOR

SUPPORTS NEEDED	SKILLS REQUIRED	PERSONALITY CHARACTERISTICS
		WANT
		DON'T WANT
		NICE TO HAVE – SHARED INTERESTS

New Adventures – Ideas for Exploration

Name_____

Scale:
1-Yes! I'd Love to do That! 2-That could be fun, I will try it 3-No Way!

Faith:
Visit churches/find a church to join 1 2 3
Join a Bible Study Class 1 2 3
Be a greeter at church 1 2 3

Food and Feeling Good:
Join an exercise class 1 2 3
Join a gym 1 2 3
Work with a personal trainer 1 2 3
Join a health/wellness class or group 1 2 3
Go for walks/hikes 1 2 3
Take a cooking/baking class 1 2 3
Join/Start Community Garden 1 2 3

Give Back:
Volunteer at a sporting event 1 2 3
Volunteer at a library 1 2 3
Volunteer cleaning up the park 1 2 3
Volunteer at an animal shelter 1 2 3
Volunteer at a soup kitchen or food pantry 1 2 3
Volunteer somewhere, but not sure where 1 2 3
Join an advocacy or civic group 1 2 3

Fun and Creative:
Take a class in art/painting 1 2 3
Take a class in crafts (sewing, drawing, crochet, scrapbook, etc...) 1 2 3
Make crafts for sale 1 2 3
Join a book club: 1 2 3
Join a dance class 1 2 3

Friends and Family
Meet some of my neighbors 1 2 3
Have cookouts and invite friends, neighbors 1 2 3

I need some help thinking of new ideas. I am not sure what is out there to do: Yes No

I am (or want to be) a _____

Who are the other _____ in the community?

1. _____
2. _____
3. _____
4. _____
5. _____

How could I meet other _____?

1. _____
2. _____
3. _____
4. _____
5. _____

Where in the community do other _____ spend their time?

1. _____
2. _____
3. _____
4. _____
5. _____

What activities does a _____ do regularly?

1. _____
2. _____
3. _____
4. _____
5. _____

What do I need to be a _____?

1. _____
2. _____
3. _____
4. _____
5. _____

Who can help me be a _____?

1. _____
2. _____
3. _____
4. _____
5. _____

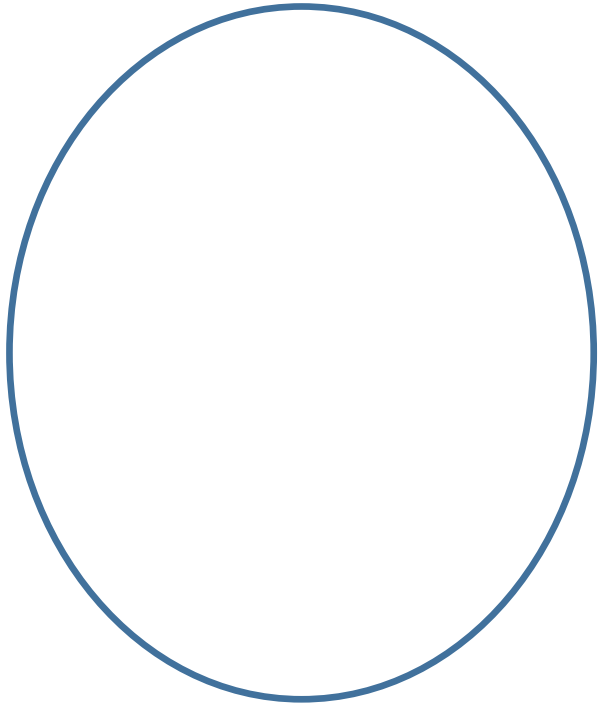
DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
One page Description FOR

WHAT PEOPLE LIKE AND ADMIRE ABOUT ME

MY PHOTO

WHAT IS IMPORTANT TO ME



HOW TO BEST SUPPORT ME

FOR A GOOD MATCH I NEED THESE CHARACTERISTICS

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OF CLARK COUNTY

PERSON-CENTERED PLAN
Communication Chart FOR

WHEN THIS HAPPENS	I DO THIS	IT USUALLY MEANS	AND I WANT YOU TO

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PERSON-CENTERED PLAN
Good Day / Bad Day FOR

TIME OF DAY	TYPICAL	BETTER	WORSE
Morning at Home			
Commute			
Morning at Work			
Lunch			
Afternoon at Work			
Commute			
Evening			
Overnight			

DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
Morning Routine FOR

TIME	ACTIVITY
6 AM	
6:15 AM	
6:30 AM	
6:45 AM	
7 AM	
7:15 AM	
7:30 AM	
8 AM	
8:15 AM	
8:30 AM	
8:45 AM	
9 AM	
9:15 AM	
9:30 AM	
9:45 AM	
10 AM	
10:15 AM	
10:30 AM	
10:45 AM	
11 AM	
11:15 AM	
11:30 AM	
11:45 AM	
12 NOON	

_____'s Comfort and Celebration Rituals

Contributors:

Comfort Rituals	Celebration Rituals

Positive Rituals Survey

For:

Contributors:

What rituals help to create a positive experience and good day? Select rituals from the list below, and add others that may also be important. Complete a more detailed description for appropriate routines/rituals.

List of Rituals/Routines	Description
Morning (getting up) Rituals	
Nighttime (going to bed) Rituals	
Arriving at work, school, or training Rituals	
Arriving at home Rituals	
Sunday Rituals	
Regular Weekly Rituals	
Birthday Rituals	
Holiday Rituals	
Other Celebration Rituals	
Comfort Rituals	
Other Rituals	

2 Minute Drill

For:
Contributors:

In 2 minutes tell me:

- What should I know (important to/important for), and
- What should I do to make it a meaningful, safe, and enjoyable day for the person?"

Important To

Actions:

Important For

Actions;

Reframing Reputations

For:

Contributors:

What is the reputation? _____

1. Are there ever circumstances where this can be positive? If yes, what is it called?
   _____

2. Does the "behavior" demonstrate or reflect something that is *important to* the person?
   _____

3. If the "behavior" truly is negative, what is the support strategy?
   _____

Then ask…

Given what we have learned:

1. Are there things that are present in the person's life that need to change?
   E.G .How the person lives; what the person is asked to do; who the person lives with?

2. Are there things that we need to do differently?
   I.E. How the person is supported?

Like & Admire – Talk To and Listen To

For:
Contributors:

What do you like about _____	What do you admire about _____	When's the last time you had fun together?

_____'s Comfort and Celebration Rituals

Contributors:

Comfort Rituals	Celebration Rituals

Risk Analysis Tool

Where is the risk identified? Locations

Name of risk?

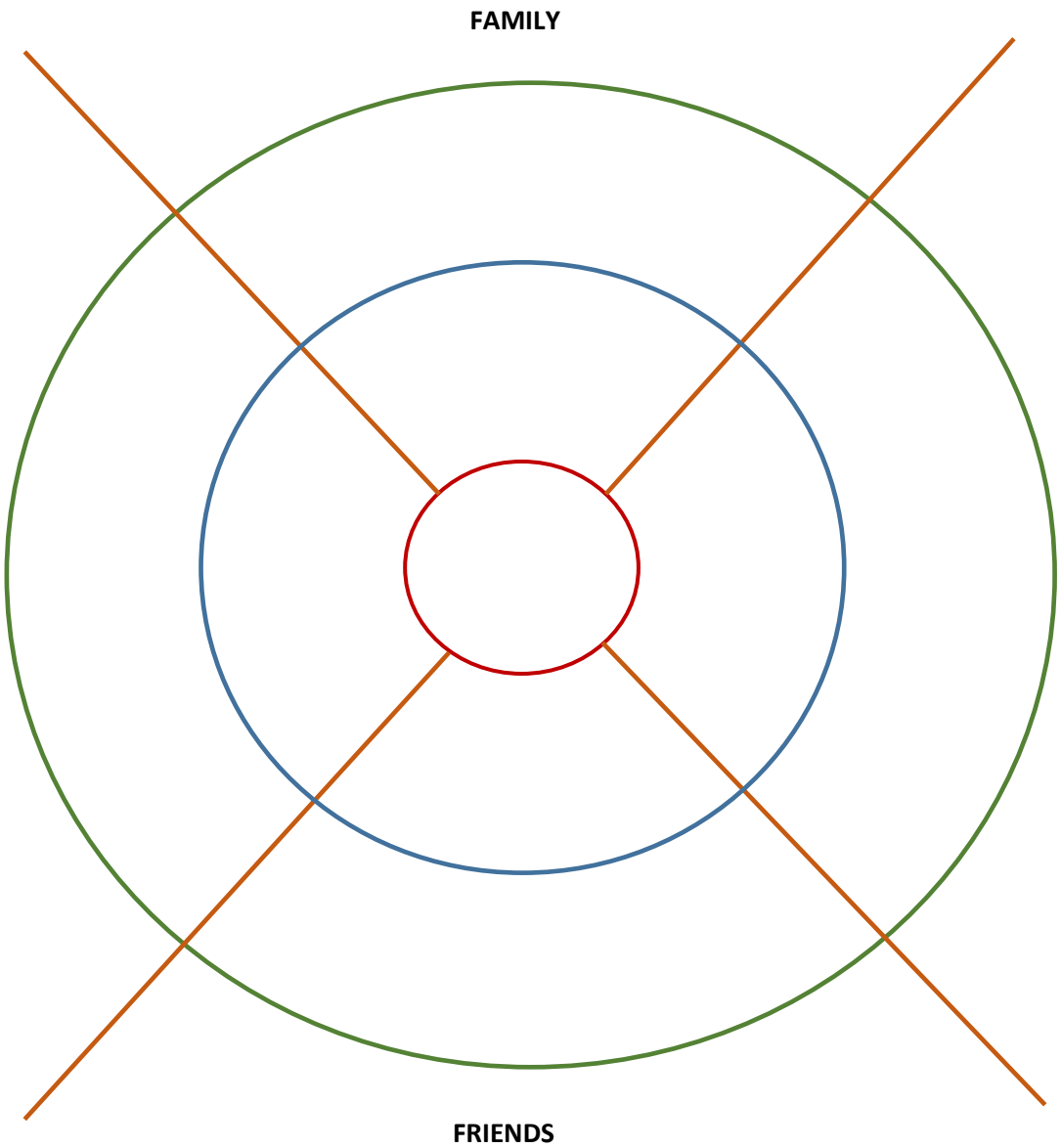
Description of Risk, (what does it look like)

What is the individual trying to communicate?

How to address risk? Adaptions - Locking items vs adding staff, what's more intrusive?

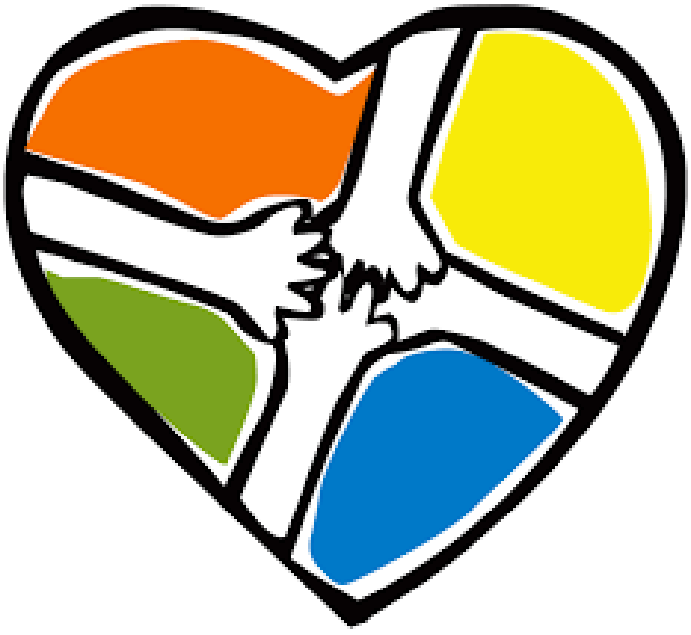
DEVELOPMENTAL DISABILITIES OF CLARK COUNTY

PERSON-CENTERED PLAN
People Map FOR



DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY

Independent Provider Orientation Handbook



Glossary & Abbreviations

1. **PCP** also known as the Person Centered Plan, previously the IP or Individual Plan
2. **SSA-**Service and Support Administrator, formerly known as Path Coordinators
3. **DODD**-Ohio Department of Developmental Disabilities
4. **UI** or **UIR**-Unusual Incident/ Unusual Incident Report
5. **MUI**-Major Unusual Incident
6. **IA**-Investigative Agent
7. **DDCC**-Developmental Disabilities of Clark County

How to access rules governing services

Visit Dodd.ohio.gov

→Click on "Forms and Rules" in the blue bar across the top of the page

→Click on "Rules in Effect" for current rules

→To stay up to date or participate in public comment/hearings on proposed rule changes, click on the "Rules under development" option.

Overtime Rule and Reporting Procedure

Rule 5123:2-9-03 Home and community-based services waivers - overtime and limit on number of hours in a work week an independent provider may provide services

Please review the full rule under the "Rules in Effect" page on DODD's website for the full parameters on this rule and your reporting requirements. See Clark County's Emergency Reporting Procedure attached at the end of this handbook.

As an Independent Provider, YOU are required by the Ohio Department of Developmental Disabilities to maintain your own certification and meet the rule requirements based on the services you provide. Included on the following pages are some of the key responsibilities you have as an Independent Provider.

Your Person Centered Planning Responsibilities

- You will need to be trained on the PCP (Person Centered Plan) by the SSA (Service and Support Administrator), and sign an agreement to the services before you can start providing services. A start date for you will be confirmed by the SSA. You will also need to participate in team planning meetings and sign an agreement of the services prior to the PCP start date each year/with revisions as requested.
- The PCP is the authorizing document, meaning that it tells you what you are being paid to provide. The services you provide an individual, and the frequency of these services, must line up with the individual's PCP, and therefore reflect what is important to and for them.
- You must keep a copy of the current PCP with your records. You should receive an emailed copy of the PCP at least 15 days prior to the plan start date, as well as with any revisions. All PCPs will be sent by email and you are required to open them and review. These emails are encrypted for confidentiality reasons, so you will need to follow the steps in the email to set up an account to open the PCP attachments. If you have not received a copy of the PCP prior to the individual's start of their plan year, you will need to contact the individual's SSA to follow-up.
- When you receive the PCP, to remain in compliance you must promptly update your service documentation to reflect any changes to the services you are responsible for and documenting on.
- You are an important PCP team member and you have valuable input to share in the planning process. If something in the PCP is not accurate, you need to let the SSA know.

Documentation

DOCUMENTATION REQUIREMENTS

For any service you provide, you must have documentation of that service.
Each service has its own documentation requirements, which can be found within the rule for each service.
The Rules can be found at https://dodd.ohio.gov by clicking on Forms & Rules, then Rules in Effect.
Your documentation can appear any way you want it to, but MUST contain all the required elements. Template forms can be found on:

- DODD https://dodd.ohio.gov/wps/portal/gov/dodd/forms-and-rules/forms/forms (Look under "Template" for HPC, and other doc templates)
- DD of Clark County (https://clarkdd.org/provider-info-resources/)

THINGS TO REMEMBER

- Documentation should be maintained in an accessible location.
- Invoices submitted for payment or billing records are NOT considered documentation. Ensure your documentation meets the requirements for the service you are providing.
- You must maintain your documentation records for 6 years.

COMMONLY USED SERVICE DOCUMENTATION REQUIREMENTS

Homemaker Personal Care	HPC Transportation	Shared Living
Type of Service, Date of Service, Place of Service, Name of Individual Receiving Service, Medicaid Number of Individual, Name of Provider, Provider Identifier / Contract Number, Written or electronic signature of the person delivering the service; initials if the provider has corresponding signature and initials on file, Group size in which the service was provided, Description and details of the service delivered that directly relate to the services specified in the approved service plan , Number of units of the delivered service or continuous amount of uninterrupted time the service was provided, Times the delivered service started and stopped	Type of Service, Date of Service, Name of Individual Receiving Service, Medicaid Number of Individual Receiving Service, Name of Provider, Provider Identifier / Contract Number, Origination and destination points of transportation provided, Total number of miles of transportation provided, Group size in which transportation is provided, Written or electronic signature of the person delivering service, or initials if provider has corresponding signature and initials on file, Description and details of the services delivered that directly relate to services specified in the approved service plan	Type of Service, Date of Service, Place of Service, Name of Individual Receiving Service, Medicaid Number of Individual, Name of Provider, Provider Identifier / Contract Number, Written or electronic signature of the person delivering the service; initials if the provider has corresponding signature and initials on file, Group size in which the service was provided, Description and details of the service delivered that directly relate to the services specified in the approved service plan

Incident Reporting/Tracking Requirements

- **KNOW THE RULE!** OAC 5123-17-02. If you are unsure or need a refresher, you can always go to DODD MyLearning and take the latest, FREE MUI/UI training.
- **REPORTING:** To report an incident, contact our MUI department (see contact information on the following page. You will need to complete an Incident Report Form (UIR). You can complete the online form on our website in the Major unusual and unusual incidents section of our provider information and resources tab→ Online Form. A physical form is also included in this packet which you can scan and email or fax, This form can also be found on our website under Providers--> Information and resources→MUI/UI Reporting→ "Online Submittal Form"

    - Your annually required training on Major Unusual Incidents (MUI), and Incident Reporting will give you details of when and what you are required to report. The next page of this handbook also summarizes your reporting requirements and reporting timelines.

- **TRACKING of Major Unusual and Unusual Incidents**: You need to maintain an Unusual Incident log for each month. Even if there are no incidents to report, you will need to have a log completed to show you are mindful of the tracking. The log has to have verification documented that it was reviewed monthly and what was done with the findings. Either a trend/pattern was discovered and a prevention put into place or no trends/patterns noted. This needs to be signed and dated when it was reviewed. You can also find the UIR log on our website in the Provider link under "Information and resources"under Documentation forms- "Fillable UI Logs."

- You are required to provide your incident tracking for MUIs to our Investigative Agent (IA) Department annually. You will need to complete the analysis report and send it to MUIreport@clarkdd.org. You will email one report each year for January 1st through December 31stof the previous year. Find the form in this packet or obtain from Marci Dowling.

- You are required, quarterly, to send your monthly unusual incidents log to MUIreport@clarkdd.org as well.

Incident Reporting Guidelines

Required Notifications: must be made the same day ☐ Guardian, advocate, or person identified ☐ SSA for individual ☐ Licensed or certified residential provider ☐ Staff or family in the home	**MUI Reporting**: During business hours, and after hours: Call: (937) 328-5245 Submit Online Form: Clarkdd.org/ui-mui/ Email: MUIreport@clarkdd.org Fax: (937) 328-4575

MUI = Major Unusual Incident (CategoryA)	**MUI = Major Unusual Incident (Category B&C)**	**UI = Unusual Incident**
Report to DDCC within **4 hours** and Report **immediately** to Law Enforcement or Children Services in cases of suspected child abuse (up to age 22): ○ Accidental or suspicious death ○ Exploitation ○ Neglect ○ Prohibited Sexual Relations ○ Misappropriation ○ Physical Abuse ○ Sexual Abuse ○ Verbal Abuse ○ Failure to Report ○ Rights Code Violation	Report to DDCC the within **4 hours:** ○ Attempted Suicide ○ Death other than accidental or suspicious death ○ Missing Individual ○ Medical Emergency ○ Peer to peer act ○ Significant Injury ○ Law Enforcement ○ Unapproved Behavior Support ○ Unscheduled Hospitalization	Report to DDCC by **3p.m. the next working day:** Include but not limited to: ○ Minor medical emergencies: dental, falls, etc. that do not require doctor visits ○ Emergency room or urgent care treatment center visits (not requiring hospitalization ○ Overnight relocation of an individual due to fire, natural disaster, or mechanical failure ○ A minor incident involving two individuals served ○ Rights code violations or unapproved behavior supports **without** a likely risk to health and welfare ○ Program Implementation incidents-failure to follow a person centered support plan when such failure causes minimal risk or no risk Ex: no supervision for a short period, car accidents without harm, self-reported incidents with minimal risk

Developmental Disabilities of Clark County Rev. 9/17, Rev. 3/18, Rev. 6/18, Rev.4/19, Rev. 4/21
Dev.12/2016; Rev.3/2017; Rev.8/17 by Greene County Board of DD

Your Ongoing Training Responsibilities

- You must complete annual training to include the following:
  - Role and responsibilities of independent provider with regard to services including person-centered planning, community integration, self-determination, and self-advocacy
  - Individual Rights
  - Requirements of Rule 5123:2-17-02 including Health and Welfare Alerts issued since previous year's training (MUI/UI)
  - Training can be completed online for free through DQDD - https://dodd.ohio.gov/wps/portal/gov/dodd/about-us/training/training- you will use your DODD log-in
  - You may also check out in-person trainings offered at DDCC by checking our training calendar at https://clarkdd.org/training-calendar/
- There are additional training requirement depending on the service you are providing. Those requirements can be found within the rule of the specific service.
- You must maintain your CPR and First Aid Certifications
  - DODD will not accept online training – requires in-person skills check
  - Training must be completed by American Red Cross or American Heart Association certified instructors
- You are responsible for tracking and maintaining your training requirements. You could be audited locally or by DODD at any time.

	Career Planning	Ind. Emp. Support	NMT	Money Mgmt.	Informal Respite	HPC Transport	HPC	Shared Living
8 hours of annual training	X	X		X			X	
CPR & First Aid	X	X	X		X	X	X	X
Provider's role/ responsibility w/ regard to Person Centered Planning, Community Integration, Self-Determination & Self-Advocacy	X	X	X	X	X	X	X	X
Individual Rights	X	X	X	X	X	X	X	X
MUI Rule w/ a review of Health & Welfare alerts	X	X	X	X	X	X	X	X
Services that comprise Career Planning	X							
Services that comprise Ind. Emp. Support		X						
Topics that enhance skills and competencies related to the provision of money management				X				
Requirements relative to provider's role in providing behavioral support							X	
Activities required to meet individual's needs					X			

Recertification

- You are responsible for knowing your certification expiration date and for the renewal of your certification every 3 years.
- To avoid having a lapse in your certification and/or billing, DODD is asking that you submit your application and supporting documentation **90 days prior to your expiration date**.
- To complete your recertification, go to dodd.ohio.gov and click “Login”(person icon in top right corner) Click “Applications” and choose “PSM-Portal” to complete your reapplication. If you need assistance with this process or use of a computer, please contact shess@clarkdd.org or 937-346-0740.
- You will need the following documents
    - **Current report from the Bureau of Criminal Identification and Investigation (BCII):** *Find more organizations that offer Web Check on the Ohio Attorney Generals' website.*
    - **First Aid Certification:** Valid American Red Cross or equivalent certification in First Aid *Find an American Red Cross First Aid training near you.*
    - **CPR Certification:** Valid American Red Cross or equivalent certification in CPR *Find an American Red Cross CPR training near you*
    - **Completion of Annual Required Training:** Evidence of completion of annual training on MUI, Client Rights, AND provider's role and responsibilities with regard to services including person-centered planning, community integration, self-determination, and self-advocacy.
    - **Additional Documents may be required based on the services you are certified to provide.** See the rule for each service.

For more information about your responsibilities regarding your certification and the specific services you provide, please refer to the DODD Rules. These can be found at www.dodd.ohio.gov. Click on "DODD Forms & Rules" then "Rules in Effect”. The rules are listed in numerical order. Click on the number of the rule to open it. You can use control + F for the "Find" function and type in the keyword of the rule you're looking for. For example control + F, type "homemaker" which will highlight all rules/appendices with "Homemaker" in the title.

Billing for Services Provided

BILLING REQUIREMENTS

You can only bill for services that you have provided that are identified in an approved service plan AND have documented. *Billing waiver can take 16-21 days to receive payment. *Billing local funds can take 30 days.

You are responsible for the accuracy of your billing. Errors will delay payment.

You can choose to use a billing agent, the form is available here (https://dodd.ohio.gov/wps/portal/gov/dodd/forms-and-rules/forms/Provider-Request-for-Association-with-Billing-Agent)

You can submit the billing as often as you would like. Billing claims are pulled into the system for processing at noon on Wednesdays and it takes 3 weeks for the claim to process.

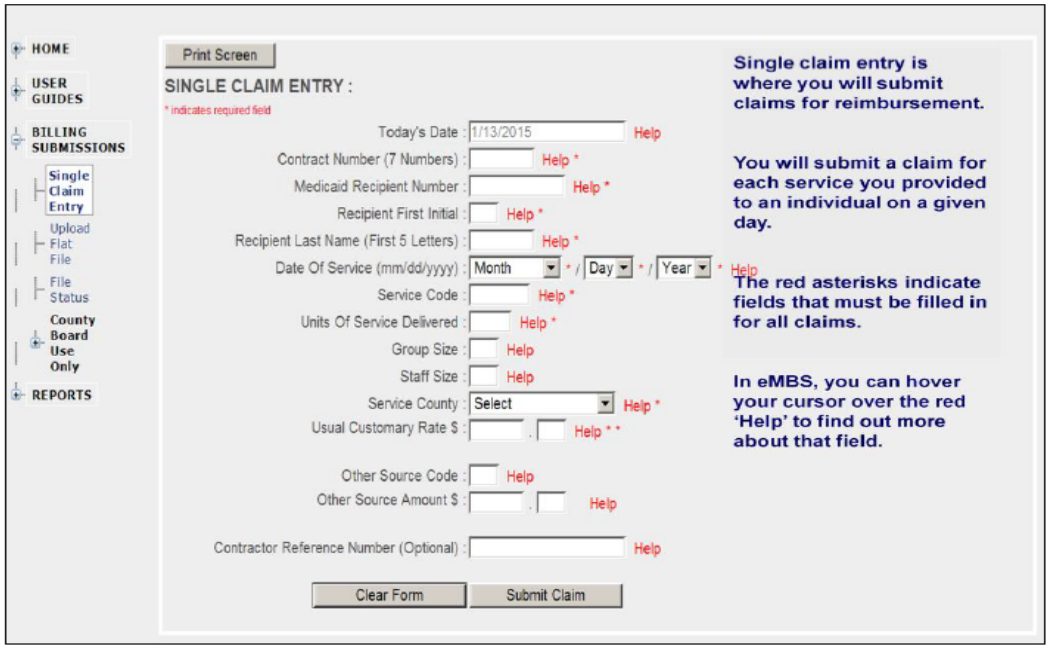
If your claim is denied, or there was an error; you can adjust your billing and resubmit it for processing. You have 350 days from the date of service to submit your claims.

Information can be found on:

- DODD https://dodd.ohio.gov/wps/portal/gov/dodd/providers/billing/billing+agent

SUBMITTING CLAIMS

When you want to bill, sign in to your DODD Account and access the application “eMBS”
Select “Billing Submissions” from the menu on the left side of the page, then “Single Claim Entry”
Fill out the following for each claim you are making. **Each person, each day are separate entries.
Billing codes and usual customary rate information can be found in the Appendix for the rule of each service.



Record Keeping

DOCUMENTATION

- Keep all of your documentation current and up to date
- You should document all services you provide as soon as you are able
- BEST PRACTICE- Have an active file with your current documentation as well as the individual's service plan that corresponds with the document and maintain any prior span documentation along with the service plan, clearly labelled
- Keep your documentation easily accessible

UI / MUI

- Keep copies of all Incident Reports that are completed
- Maintain a monthly UI Log, even if you have 0 incidents. Review Monthly.
- Complete, submit and retain for your records the Annual MUI Analysis

YOUR TRAINING

- Maintain records of ALL trainings you complete and all certificates you receive
- It is your responsibility to ensure you are in compliance with all training requirements and have the documentation / certificates to prove you have completed all requirements

TIMELINE FOR DOCUMENTATION & RECORDS

COMPLETE UP TO DAILY-

- Service documentation
- Incident reports (if they occur)

COMPLETE MONTHLY-

- Completed, reviewed and signed service documentation
- UI Log and log review (even if there are 0 incidents)

ANNUALLY

- MUI Analysis (send to MUIreport@clarkdd.org)
- Training-annual requirements

AS NEEDED

- Your training (CPR/FA, EVV, rule updates, etc.)

Compliance Reviews

INFORMATION

At least once in your certification span, you will undergo a compliance review.

WHAT IS REQUIRED FOR A REVIEW?

You can find the Compliance Review Tool here:
https://dodd.ohio.gov/wps/portal/gov/dodd/compliance/compliance-review-tools/006-independent-tool
You can find the list of required documents for a Compliance Review here:
https://dodd.ohio.gov/wps/portal/gov/dodd/compliance/compliance-review-tools/014f-independent-required-documents-list

TIMELINE FOR A REGULAR REVIEW

- 90 days prior to the review- you will receive notification that a review will occur
- 60 – 45 days prior – reviewer will contact you to set the review date
- Onsite Review- review occurs

AFTER THE REVIEW

Once the review is complete:

- If you have received no citations- you will receive a letter signifying that you have completed your review with no citations
- If you have received any citations- you will receive a compliance summary and a request for a Plan of Correction (POC)
    - Within 14 days of receiving the request, you must submit your POC or you can appeal the citation(s)
        - If the POC is approved- you will receive a POC approval letter and a completed compliance survey
        - If the POC is disapproved- you will receive correspondence from the reviewer asking for additional information and you will have to resubmit a POC
    - Within 90 days of POC approval- the reviewer will verify that the POC has been implemented

Medication Administration

- DODD approved medication administration training is required if you administer medication to an individual.
- If you have questions about medication administration, please email shess@clarkdd.org or reference rule **Chapter 5123:2-6**
- If you are certified in Medication Administration and providing Medication Administration assistance to any individual you serve, you will be subject to a Medication Administration review:

Medication Administration Review

5123:2-6-07 (D)(3) The quality assessment registered nurse shall complete quality assessment reviews so that a review of each provider location in the county where certified developmental disabilities personnel perform health-related activities, administer oral prescribed medication, administer topical prescribed medication, administer topical over-the-counter musculoskeletal medication, administer oxygen, or administer metered dose inhaled medication is conducted at least once every three years. The quality assessment registered nurse may conduct more frequent reviews if the quality assessment registered nurse, county board, provider, or department determines there are issues to warrant such.

Medical Appointments and tracking

If you are designated in the Person Centered Plan as being responsible for medical appointments and follow-up, you are required to document the completion of this service as with any other service you are designated in the plan to provide. It is best practice to have a tracking system for these appointments and follow-up appointments, particularly when there is an unusual or major unusual incident that requires medical attention, it is important to have documentation from the medical professional and any follow-up appointments AND to provide this to the Investigative Agent for MUIs. Please see the template for professional appointments included in this packet. This can be used for eye appointments, dentists, therapy, general practitioners, or any other professional appointments.

Personal Funds Management

If you are designated in the Person Centered Plan as being responsible for assisting a person with managing their personal funds, please refer to the "Personal Funds of the Individual" rule **5123:2-2-07**. Please see example funds forms included in this packet for each type of funds which are intended as a resource to aid you in creation and tracking of information. It is your responsibility to ensure that all required information (as outlined in the rule) is included in your form. The best place to check requirements is on the "Rules in Effect" page at dodd.ohio.gov to get the latest and most accurate guidelines.

- It's important to note that per the rule, someone "other than the person who provides direct assistance to the individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider shall conduct the reconciliations required" in the rule.
- There are also specific requirements for depositing checks, timeframes for turning over funds when you cease to provide services, among other things.

Provider Checklist:
AFTER CERTIFICATION APPROVAL

I HAVE MY APPROVAL LETTER, WHAT'S MY FIRST STEP?

- ☐ If an individual is waiting for your approval to begin services, contact the SSA and provide a copy of your approval letter. This will be emailed to you from DODD upon your approval
- ☐ Notify the Provider Liaison, Sarah Hess, to be added to the Clark County provider database 937-346-0740 or complete the form on our website clarkdd.org/provider-information-form
- ☐ Review the rule(s) for the services you plan to provide.
- ☐ Service Documentation and Billing Training within 60 days of providing services. Billing and Documentation training can be found online at mylearning.dodd.ohio.gov.
- ☐ Create your documentation. Be sure to include all required elements listed in the service rule
- ☐ Sign up for emails from DDCC about requests for providers, DODD updates/changes, and provider meetings. Visit clarkdd.org and click "Sign up for news" and choose your lists. Also join our provider Facebook page at facebook.com/ddccproviders.

Once I'm providing services, what are my responsibilities

- ☐ REPORT UNUSUAL and MAJOR UNUSUAL INCIDENTS. Visit https://clarkdd.org/ui-mui/ for printable forms (see samples in this handbook) or to submit a report online.
- ☐ Keep monthly UI/MUI log. If no incidents occurred, mark "no incidents". Send these to muireport@clarkdd.org 4 times per year. See sample log and guidelines. Contact the MUI department for reporting dates

Month completed_____Month completed_____Month completed_____Month completed_____

- ☐ MUI Annual reporting. You must report even if you have no incidents occurring. See handbook for reporting details and form.

  Annual: January1 through December 31____

- ☐ **CHECK YOUR EMAIL** on a regular basis. Compliance review communication will **ONLY** be shared via email. DDCC also emails updates and important provider information to your provider email address for those who have signed up for our mailing list.
- ☐ Communicate with the service team. Keep the SSA, guardian, and other providers up to date on any changes. Stay involved and communicate!
- ☐ Attend service team meetings
- ☐ Stay up to date on trainings and certification requirements. Keep a list of due dates to help keep you on track!
- ☐ Stay up to date on rule changes for providers and services. Sign up for DODD and DDCC updates to stay informed
- ☐ Keep all documentation for 6 years from the date you paid for the service.

Contact Information

If you have questions about any of the responsibilities and requirements included in this handbook, please contact:

Sarah Hess, Provider Liaison
Developmental Disabilities of Clark County
(937) 346-0740
Shess@clarkdd.org

For questions related to your user account with DODD, or applications on DODD's website, please contact:

DODD Support Center
1-800-617-6733
Opt.3-Provider Certification
Opt.4-Security (user account issues, password resets)

For questions related to incident reporting, please contact:
(937) 328-5245
muireport@clarkdd.org

To connect with other DD of Clark County employees:
(937) 328-2675

The following sample forms are meant to aid you in creating documentation and tracking services. You are responsible for knowing the documentation requirements governing your provided service type. Changes occur frequently in our field and you are encouraged to check the current rules found on the "Rules in Effect" page at dodd.ohio.gov. Please contact Sarah Hess for assistance in accessing these rules if needed.

DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY
WHERE PEOPLE GROW

To: Independent Providers serving individuals in Clark County

From: Jennifer Rousculp Miller, Superintendent

Shannon Chatfield, Director Community Living Services

Re: OAC 5123:2-9-03, Emergency Reporting Procedure

Date: April 16, 2018

As we continue to work with teams regarding service hours, we have also updated the reporting procedure for emergency situations that require additional hours outside of the current service authorization. We hope these revisions will simplify the process for you. Thank you for your continued support and dedication to the individuals who receive services from Developmental Disabilities of Clark County.

If it is between the hours of 8:00am-4:00pm, Monday-Friday please contact the CLS front office at (937) 328-2683 and request to talk to the individual's assigned SSA. If the SSA is unavailable, please request to speak to a CLS supervisor. You must talk to a staff member please do not just leave a message on the assigned SSA's voicemail.

1. If after normal business hours or on a weekend, please contact the CLS on-call SSA at (937) 215-6983 to report the emergency. The on-call SSA will email the individual's assigned SSA and SSA supervisor to report the emergency concern.
2. When calling to report an emergency that requires additional hours please complete the following:
    a. This call shall be made within 4 hours of the emergency occurrence
    b. The information provided to CLS staff should be what constituted the emergency that will have you work over your current authorized hours
    c. Report the number of additional hours that will be anticipated to be worked

The following business day, upon receipt of the email reporting the emergency and the additional hours worked, the SSA will contact team members to determine whether adjustments need to be completed to the service authorization.

Provider Name: _____

Provider Number: _____

ISP Span Date: _____

Service Documentation

Medicaid Number: _____

Service Type: _____

Name: _____

Month/Year: _____

Support	Frequency	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

R=Refusal H=Hospital F=Family V=Vacation W=Work S=School

Outcome Documentation

Month/Year:

Outcome 1:																															
My outcome is to….																															
Action Step	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Action Step	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Action Step	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Outcome 2:																															
My outcome is to….																															
Action Step	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Action Step	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Print Name	Signature	Initials

Please explain all missed frequenecies below, include the date of service and staff initials

Ohio | Department of Developmental Disabilities

DODD – Possible or Determined MUI Report Form

Provider Name & Address

Individual's Name:	DOB:
Address:	City/County:

Date of Incident: Time of Incident: AM PM

Location of Incident (home in bathroom, at the mall, lunchroom at work):

Description of Incident (Who, What, Where, When):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Injury – Describe Type & Location:

_____
_____
_____

Immediate Action to Ensure Health & Welfare of Individuals:

_____
_____
_____

Name of PPI(s):	Relationship to Individual:
Witnesses to Incident:	Others Involved:

Type of Notification	Name/Title	Date/Time
Guardian / Advocate/Family		
SSA		
Licensed or Certified Provider		
Staff or Family living at the Individual's home		
LE (Name, Badge Number, Jurisdiction, Contact Info)		
Children's Services (if applicable)		
County Board		
Administrator (Required for ICF)		
Senior Management		
Other Providers of Service		

Additional Information/or Administrative Follow-Up:

A. Further Medical Follow-up:

_____
_____
_____

B. Administrative Action:

_____
_____
_____
_____

Printed Name: _____

Signature: _____ Title: _____ Date:_____

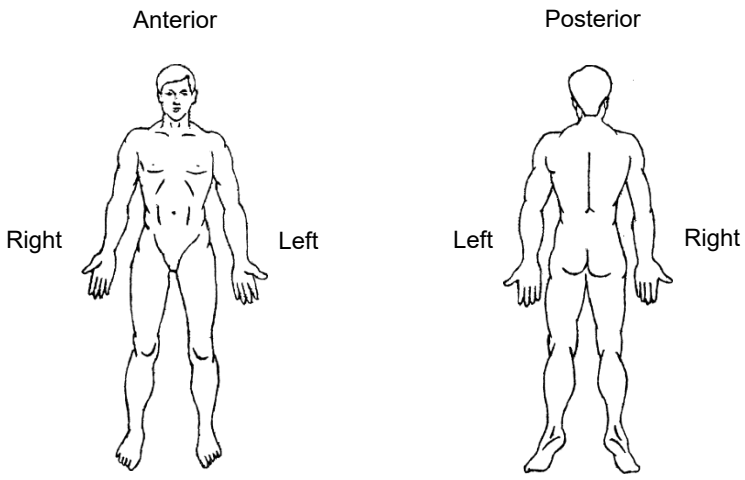
Body Part Injured:

Head or Face	Neck or Chest
Mouth / Teeth	Abdomen
Hands/Arms	Back/Buttocks
Feet/Legs	Genitals

Detailed description of area(s) injured:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Check All Areas Injured



Causes and Contributing Factors:

_____
_____
_____
_____
_____
_____

Preventive measures: (For Provider's internal use)

_____
_____
_____
_____
_____
_____
_____

Administrator Review: _____ Date: _____

Ohio | Department of Developmental Disabilities

Law Enforcement MUI Form

Individual's Name:_____ **Date Form Completed:** _____

Incident Date:_____ **MUI Number:**_____

Person Completing Form:_____ **Provider:**_____

Title:_____

Contact Information:_____

HISTORY / ANTECEDENTS:

Please list what led to the individual being charged, incarcerated, arrested or tased. Provide a timeline and whether this individual has a history of law enforcement involvement. Provide details of prevention measures from prior incidents.

_____
_____
_____
_____
_____
_____
_____

CRIMINAL CASE INFORMATION:

Law Enforcement Entity: _____
Outcome of Criminal Case: _____
Contact Information for Arresting Officer: _____
Incarceration Location: _____
General Population?_____**Probation?** _____ **Parole?** _____

SUPERVISION LEVEL:

Did the individual have a supervision requirement? If so, describe the supervision level. Was the supervision level met? Did the staff know about the supervision required? Was the staff trained on the implementation of the supervision requirements?

_____
_____
_____
_____

INJURIES / MEDICAL NEEDS:

Were there any injuries to the individual or anyone else involved in the Law Enforcement MUI? Did the individual receive timely medical attention? Are the individual's medical needs known – especially if the individual is incarcerated?

_____
_____
_____
_____
_____
_____
_____
_____

DESCRIPTION:

Describe in detail the incident.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CAUSE AND CONTRIBUTING FACTORS:

Supervision not met	**Excessive noise**	**Medication changes**
Staff ratio was not appropriate	**1:1 attention unavailable**	**Illness**
Diet not followed	**Peer aggression**	**Possible Hallucination**
Asked to complete task	**Outing canceled**	**Loss of important relationship**
Change in routine	**Control issues - staff/family/peers**	**ISP/BSP followed**

Other:

PREVENTION MEASURES:

Physical/Social Environmental Change	**Medication Changes**
Agency Policy/System Change	**Follow up appointment scheduled**
Staff Training	**PT/OT/Speech referral made to address communication or mobility concerns**
Counseling	
Team Meeting to address ISP Changes	**Diet change ordered**
Appointment with Medical Care Provider	**Home Health Care**

Other:

INVESTIGATIVE AGENT REVIEW:
Comments & Questions:

_____
_____
_____
_____
_____

IA NAME: _____ **REVIEW COMPLETED DATE:**_____

Ohio | Department of Developmental Disabilities

Unanticipated Hospitalization MUI Form

Individual's Name: _____ **Date Form Completed:** _____

Date of Hospitalization: _____ **MUI Number:**_____

Name of Person Completing Form: _____

Title: _____ **Provider:** _____

Contact Information: _____

HISTORY / ANTECEDENTS:

Please list what led to the hospitalization and the medical history of the individual. Have there been recent similar illnesses? What was the health of the individual in the 72 hours leading up to the hospitalization?

_____
_____
_____
_____
_____
_____
_____

TYPE OF HOSPITALIZATION:

Medical Psychiatric

How many days was the individual in the hospital?

REASON FOR HOSPITALIZATION – Please mark all that apply:

Abdominal Pains	Cancer	Ingestion- PICA
Abnormal Blood Levels	Chest Pains	Kidney
Absent Pulse	Debucitus Ulcer	Medical Error
Allergic Reaction	Dehydration/Volume Depletion	Observation/Evaluation
Altered State	Edema	Placed item in Orifice
Baclofen Pump Issues Blood Pressure	Emesis (vomiting/diarrhea)	Pneumonia and Influenza
Blood Sugar Levels	Gallbladder	Seizures
Body Temperature Variations	Generalized Pain	Shunt
Bowel Obstruction	Heart Problems	Stroke
	Impaired Respiration	Syncope Uncontrollable
	Infection	Bleeding

Other:

SYMPTOMS AND RESPONSE:

What were the individual's symptoms – over what length of time – and what was the response?

_____
_____
_____
_____
_____
_____
_____

DIAGNOSIS AND DISCHARGE SUMMARY:

Please describe in detail the individual's diagnosis and discharge summary. Please attach discharge summary.

_____
_____
_____

FOLLOW-UP APPOINTMENTS / CHANGES TO MEDICATIONS / CONTINUING CARE

Please list the changes and the continuing needs of the individual along with the person responsible for these. Please attach discharge paperwork and follow-up appointment outcomes.

_____
_____
_____
_____
_____
_____

CAUSE AND CONTRIBUTING FACTORS:

Medication Change	Fall- Due to Mobility Issues
Choked on Food	Aspiration Due to Improper Diet Texture
Medication Error	Failure to Provide Timely Medical Care
Fall-Due to Environmental Factors	Staff Did Not Monitor Input/Output of Fluids

Other:_____

PREVENTION MEASURES:

Physical/Social Environmental Change	Medication Changes
Agency Policy/System Change	Follow up Appointment Scheduled
Staff Training	PT/OT/Speech Referral made to address communication or mobility concern
Counseling	Diet Change Ordered
Team Meeting to address ISP Changes	Home Health Care
Appointment with Medical Care Provider	

Other:_____

INVESTIGATIVE AGENT REVIEW:

Comments & Questions:

_____
_____
_____
_____
_____
_____
_____
_____

IA NAME: _____ Review Completed Date: _____

Ohio | Department of Developmental Disabilities

Unapproved Behavioral Support MUI Form

Individual's Name: _____ Date of UBS: _____ Name of Person Completing Form: _____ Title: _____ Contact Information: _____	Date Form Completed: _____ MUI Number: _____ Provider: _____

UBS/HISTORY ANTECEDENTS

Please list what led to UBS. Provide a time line and whether this individual has a history of this behavior. Provider details of prevention measures from prior incidents.
How many times was the intervention/support used? How long (total) was the individual restrained?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

BEHAVIOR STRATEGIES

Did the individual have behavioral support strategies outlined in their service plan? Did the staff know about the strategies? Was the staff trained on the implementation of the behavioral support strategies?

_____
_____
_____
_____
_____
_____

TYPE OF UBS (CHECK ALL THAT APPLY)

Physical Restraint:

- Baskethold
- Multiple Person Carry
- Multiple Person Escort
- One Person Carry
- One Person Escort
- One Person Restraint
- Physically Prompted Hands Down with Resistance
- Prone
- Restraint of Multiple Appendages
- Seated Restraint
- Side Restraint
- Standing Restraint
- Supine
- Time Out- list details of time-out, including length of time:_____
  _____
- Other: _____

Ohio | Department of Developmental Disabilities

Unapproved Behavioral Support MUI Form

(CHECK ALL THAT APPLY)

Chemical Restraint:

- Anti- Anxiety
- Anticonvulsant
- Antidepressant
- Antipsychotic
- Mood Stabilizer
- Other: _____

Mechanical:

- Full Body-papoose Board Wrap
- Full Body-seated Position
- Full Body-supine Position
- Gait Belt
- Helmet
- Locked Seat Belt/Vest – not during transportation
- Mitts
- Splints
- Transportation – locked seatbelt/vest/others
- Wheelchair controls disabled
- Wheelchair for individual - not used regularly
- Other: _____

INJURIES

Were there any injuries to the individual or anyone else involved in the UBS? Did the individual receive timely medical attention?

_____
_____
_____
_____
_____
_____

DESCRIPTION

Describe in detail the intervention/support and the reason used. How was it necessary for the health and welfare if individual or other individuals?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Unapproved Behavioral Support MUI Form

CAUSE AND CONTRIBUTING FACTORS (CHECK ALL THAT APPLY)

- Supervision Not Met
- Staff Ratio Not Appropriate
- Diet Not Followed
- Asked to Complete Task
- Change in Routine
- Excessive Noise
- 1:1 Attention Unavailable
- Peer Aggression
- Outing Cancelled
- Control Issues – Staff/Family/Peers
- Medication Changes
- Illness
- Possible Hallucination
- Loss of Important Relationship
- ISP/BSP Not Followed

Other: _____

PREVENTION MEASURES (CHECK ALL THAT APPLY)

- Physical/Social environmental changes
- Agency Policy/System Change
- Staff training
- Counseling
- Team meeting to address ISP changes
- Appointment with Medical care provider
- Medication changes
- Follow up appointment scheduled
- PT/OT/Speech referral made to address Communication or mobility concern
- Diet change ordered
- Home health care

Other: _____

INVESTIGATIVE AGENT REVIEW

Comments and Questions:

_____

_____

_____

_____

_____

_____

IA NAME: _____ **REVIEW COMPLETED DATE:** _____

DEVELOPMENTAL DISABILITIES
OF CLARK COUNTY
WHERE PEOPLE GROW

Unusual Incident Log Reporting (Please report: contact DDCC for reporting month assignment at 937-346-0735)

4 times a year the County Board will request a copy of your Unusual Incident Log from every provider. Even if you have had no Unusual Incidents, state rule requires that you report in with the County Board.

The Unusual Incident Log should contain (at least) the following information for each incident reported:

- Individual's Name
- Date of incident
- Time of incident
- Any injuries that may have occurred
- Location of Incident
- Incident reported completed by and Direct Witnesses
- Description of Incident
- Contributing Factors (if any)
- Immediate Action
- Prevention Plan

Major Unusual Incidents Reporting

- **Annual (January – December) is due February 28th of the following year.**

1 time a year the County Board will request every provider to report MUI Trends and Patterns. Even if you have had no Major Unusual Incidents, state rule requires that you report in with the County Board.

- Date of Review
- Name of Person completing review
- Time period of review
- Comparison of data for previous three years
- Explanation of data
- Data for review by major unusual incident category type
- Specific individuals involved in established trends and patterns (five major unusual incidents of any kind in six months or 10 major unusual incidents within a year, or other pattern identified by the individual's team
- Specific trends by residence, region, or program
- Previously identified trends and patterns

You can report in with the County Board by:

Email: MUIreport@clarkdd.org
Fax: 937-328-4575
Mail: Investigative Unit, 2527 Kenton Street, Springfield, Ohio 45505
Telephone: 937-328-5245; If no answer, please leave a message and a phone number and someone will call you back.

UNUSUAL INCIDENT REPORT LOG

Provider/Facility:						Month/Year:	County:			
Name	UI #	Date & Time	Injury	Home Name and Address	Location	Description of the Incident (Explain the risk of Harm)	Immediate Actions Taken to Ensure Health and Welfare	Causes and Contributing Factors	Prevention Plan	UI/MUI

Reviewed by:_____ Title:_____ Date:_____

Trends and Pattern Identified? YES ☐ NO ☐

Trends and Pattern Addressed? YES ☐ NO ☐ If yes, please complete section below.

Action taken to address identified Patterns and Trends:

O.A.C. 5123:2-17-02 (M)(8) Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to, the name of the individual, a brief description of the unusual incident, any injuries, time, date, location, and preventive measures.

DODD MUI 7/22/13

UNUSUAL INCIDENT REPORT LOG

SAMPLE W/ NO INCIDENTS

Provider/Facility: Ranger Smith						Month/Year: 2019	County: Clark			
Name	UI #	Date & Time	Injury	Home Name and Address	Location	Description of the Incident (Explain the risk of Harm)	Immediate Actions Taken to Ensure Health and Welfare	Causes and Contributing Factors	Prevention Plan	UI/MUI
John Doe	-	Jan 2019	N/A	123 Maple Ln.	N/A	No incidents	N/A	N/A	N/A Reviewed 2/1/19 RS	N/A
John Doe	-	Feb 2019	N/A	123 Maple Ln.	N/A	No incidents	N/A	N/A	N/A Reviewed 3/1/19 RS	N/A
John Doe	-	Mar 2019	N/A	123 Maple Ln.	N/A	No incidents	N/A	N/A	N/A Reviewed 4/1/19 RS	N/A

Reviewed by: Ranger Smith Title: Independent Provider Date: 4/1/19

Trends and Pattern Identified? YES ☐ NO ☒ X

Trends and Pattern Addressed? YES ☐ NO ☐ If yes, please complete section below.

Action taken to address identified Patterns and Trends:

*Also could put review dates here as shown below:

Reviewed 2/1/19-RS
Reviewed 3/1/19-RS
Reviewed 4/1/19-RS

O.A.C. 5123:2-17-02 (M)(8) Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to, the name of the individual, a brief description of the unusual incident, any injuries, time, date, location, and preventive measures.

UNUSUAL INCIDENT REPORT LOG SAMPLE W/ INCIDENTS

Provider/Facility: Sunshine 123 Agency						Month/Year: January 2019	County: Clark			
Name	UI #	Date & Time	Injury	Home Name and Address	Location	Description of the Incident (Explain the risk of Harm)	Immediate Actions Taken to Ensure Health and Welfare	Causes and Contributing Factors	Prevention Plan	UI/MUI
John Doe	1	Jan 1 2019	Bruise-left knee	123 Maple Ln.	Kroger, E.Main, Springfield	JD slipped on ice in the parking lot and landed on his left knee.	DSP helped JD up, checked knee for injury, had a red spot but no abrasion. JD said he was okay. DSP held onto his arm for the rest of the walk in/out.	Untreated ice in the parking lot	DSP discussed getting boots with better traction or "yak tracks" for winter months.	UI
Larry Lin	2	Jan 6 2019	N/A	789 High St.	Home	LL vomited 3 times in the night.	Assisted LL with cleaning up vomit and providing him a trash can by his bed. Gave him water and, with his approval, placed a baby monitor in his room to monitor throughout the night to assist when needed.	LL has the flu	Took LL to the doctor first thing in the morning. He was given Tamiflu. Once feeling better, we talked about ways to prevent getting the flu-handwashing, covering your mouth, etc.	UI
Karen Jones	3	Jan 12 2019	N/A	456 Maple Ln.	Home	Refused to take her daily multivitamin	Staff LP asked KJ why she didn't want to take it-all other meds were taken without incident. KJ just shook her head. Staff asked KJ twice more over the next hour. KJ refused each time. No adverse effect	New multivitamin, but KJ could not say why she is refusing to take it.	Called KJ's doctor to notify of the refusal. Left a message on the nurse line requesting a call back.	UI
Karen Jones	4	Jan 13 2019	N/A	456 Maple Ln.	Home	Refused to take her daily multivitamin	Staff LP asked KJ why she did not want to take it. Again, she shook her head, but continued to refuse prompting over the next hour. No adverse effect.	New vitamin-unknown what she doesn't like about it.	Called KJ's doctor 3/3/19. Received a call from nurse to answer questions. Nurse said she'd speak to doctor.	UI
Karen Jones	5	Jan 14 2019	N/A	456 Maple Ln.	Home	Refused to take her daily multivitamin	Staff KG asked KJ why she didn't want to take it. KJ made a face indicating a bad taste. KG asked KJ if it tastes bad, KJ nodded once emphatically. No adverse effect.	KJ reported the new brand of vitamin tasted bad.	Called KJ's doctor and received approval to purchase new multivitamin that contained no iron. They will call in new order to pharmacy.	UI

Reviewed by: Ranger Smith Title: Program Manager Date: 4/1/19

Trends and Pattern Identified? YES [X] NO [ ]

Trends and Pattern Addressed? YES [X] NO [ ] If yes, please complete section below.

Action taken to address identified Patterns and Trends:

We saw a trend of KG refusing a new multivitamin, but through communication with a familiar staff person was able to discover that the medicine had a bad taste. We were able to request a different vitamin from her doctor and have seen no more refusals.

O.A.C. 5123:2-17-02 (M)(8) Each agency provider and independent provider shall maintain a log of all unusual incidents. The log shall include, but is not limited to, the name of the individual, a brief description of the unusual incident, any injuries, time, date, location, and preventive measures.

DODD MUI 7/22/13

Ohio | Department of Developmental Disabilities

ANNUAL REPORT – INDEPENDENT PROVIDER

INDEPENDENT PROVIDER NAME: _____

MUI ANNUAL REVIEW (January 1 through December 31) for the year: _____

Independent providers are required to complete the Annual Review by January 31 and send to the County Board by February 28.

Total Number of MUI categories for previous year: _____

Total Number of MUI categories for the same period 2 years ago: _____

Total Number of MUI categories for the same period 3 years ago: _____

Number of MUI categories by type:

MUI Categories	**Previous year**	**2 years ago**	**3 years ago**
Accidental/suspicious death			
Attempted suicide			
Death-non-accidental			
Exploitation			
Failure to Report			
Law Enforcement			
Medical Emergency			
Misappropriation			
Missing Individual			
Neglect			
Peer-to-Peer Act			
Physical Abuse			
Prohibited Sexual Relations			
Rights Code Violation			
Sexual Abuse			
Significant Injury			
Unapproved Behavioral Support			
Unanticipated Hospitalization			
Verbal Abuse			

Explain the reasons for any significant differences from year to year and any MUI categories with a high number of incidents (use additional pages as necessary):

_____

_____

_____

_____

_____

_____

_____

_____

_____

ANNUAL REPORT – INDEPENDENT PROVIDER

TRENDS and PATTERNS

Individuals with 5 or more MUI categories in 6 months or 10 or more MUIs in 12 months in the current year:_____

Name:_____

MUI types: _____

Action plans and preventive measures taken to address this trend/pattern:

_____
_____
_____
_____

Date the action plans and preventive measures were added to the individual's plan:

_____

Previous year's trends and patterns:

Name of individual:_____

Have the MUI categories involving the individual increased, decreased, or stayed the same?

_____

Were the action plans and preventive measures effective? _____
(Use additional pages to add other individuals if needed.)

Date this review was completed: _____

Name of person completing this review:_____

MUI REPORTING QUICK REFERENCE:

Report all MUIs within FOUR hours

Report regardless of where the incident occurred	
Accidental or suspicious death	Death of an individual resulting from an accident or suspicious circumstances
Attempted suicide	A physical attempt by the individual that results in emergency room treatment, in-patient observation, or hospital admission.
Death other than accidental or suspicious death	Death of an individual by natural cause without suspicious circumstances.
Exploitation	Unlawful or improper act of using an individual or their resources for monetary or personal benefit, profit, or gain.
Failure to report	A person who is required to report who has reason to believe that an individual suffered or faces substantial risk of wound, injury, disability, or condition as to reasonably indicate abuse, neglect, misappropriation or exploitation that results in a risk to the health and welfare of that individual and the person does not immediately report it.
Law enforcement	Any incident that results in the individual served being tased, arrested, charged, or incarcerated.
Misappropriation	Depriving, defrauding, or otherwise obtaining the real or personal property of an individual by any means prohibited by the Revised code.
Missing individual	An incident that is not considered neglect, when an individual's whereabouts are unknown and they are believed to be at or pose an imminent risk of harm to self or others.
Neglect	Failing to provide medical care, personal care or other support that results in or places a person at risk of a serious injury when there is a duty to do so
Peer-to-peer acts	Any incidents involving two individuals that involves • exploitation, • theft, • sexual act without consent of the other individual, • verbal act when there is opportunity and ability to carry out the threat, and • physical act or altercation resulting in medical treatment by a physician, physician's assistant, or nurse practitioner and that involves

MUI REPORTING QUICK REFERENCE:

	strangulation, a bloody nose, bloody lip, black eye, concussion, or biting that breaks the skin, or results in an individual being arrested, incarcerated, or subject to criminal charges
Physical abuse	Use of physical force that can reasonably expected to cause physical harm.
Prohibited sexual relations	A developmental disabilities employee engaging in consensual sexual conduct or sexual contact with an individual who is not the employee's spouse and for whom the employee was employed or under contract to provide care to or supervise the delivery of care at the time of the incident.
Sexual abuse; and	Unlawful sexual conduct or contact when it involves an individual
Verbal abuse	Use of words, gestures, or other communicative means to purposefully threaten, coerce, intimidate, or humiliate an individual

Report required only when the incident occurs in a program operated by a county board or when the individual is being served by a licensed or certified provider:

Medical emergency	An incident requiring emergency medical intervention to save an individual's life (Ex: Back blows, CPR, Epipen)
Rights code violation	Any violation of rights (see individual rights) that creates a likely risk of harm to the health or welfare of an individual.
Significant injury	Injury of known or unknown cause that is not abuse or neglect and results in a concussion, broken bone, dislocation, second or third degree burns or that requires immobilization, casting, or five or more sutures.
Unanticipated hospitalization	Any hospital admission or stay over twenty-four hours that is not pre-scheduled or planned.
Unapproved behavioral support	The use of prohibited measure (defined in 5123-2-06) or restrictive measure implemented without approval of the human rights committee or without informed consent of an individual or their guardian when the use of these results in a risk to the individual's health and welfare.

INDEPENDENT PROVIDER
REQUIRED DOCUMENTS LIST

Below is a list of documents that should be submitted to **reviewer name** lead reviewer, **at least 14 days prior** to the virtual compliance review on **date of review** for the months **_____.** Additional documents may be requested throughout the review. Depending on the type of waiver and services provided, some items will not apply to the review. Please contact the lead reviewer with any questions.

SECTION 1: SERVICE PLANNING for individuals in sample	**YES**	**NO**	**N/A**
1. Current individual service plan (ISP), including addendums/revisions (This will be provided by the County Board)			
2. Previous individual service plan (ISP), including addendums/revisions (This will be provided by the County Board)			
3. Assessments used to develop the service plan (This will be provided by the County Board)			
4. Plan of Care (485) signed by physician for Waiver Nursing services (*if applicable*)			
5. Current medication Self-Administration Assessment(s)			
SECTION 2: MEDICATION ADMINISTRATION for individuals in sample *(if applicable)*	**YES**	**NO**	**N/A**
1. Delegated Nursing: A. On-going nursing assessments B. Statement of delegation C. Annual staff skills checklist			
SECTION 3: BEHAVIOR SUPPORT for individuals in sample (*if applicable)*	**YES**	**NO**	**N/A**
1. Record of the date, time, duration, and antecedent factors for each use of a restrictive measure, *if applicable*			
2. If a time out room is utilized, please provide the logs			
SECTION 4: PERSONAL FUNDS for individuals in sample (*if applicable)*	***YES***	**NO**	**N/A**
1. Evidence that individuals have access to their funds as stipulated in the service plan			
2. Evidence of reconciliation of bank accounts (with bank statements) and cash accounts (including food stamp, gift card, or other cash accounts) for the months requested by someone who does not handle the individual's funds			
3. Documentation for the months requested, including ledgers, receipts, bill payments, etc. as required by the ISP			
SECTION 5: SERVICE DELIVERY & DOCUMENTATION for individuals in sample	**YES**	**NO**	**N/A**
1. Waiver service delivery documentation of services and outcomes in the ISP for the three months prior to review date for each type of service provided. See required documentation elements in the specific rule for each service: A. Career Planning (5123-9-13)			

B. Individual Employment Support (5123:2-9-15) C. Non-Medical Transportation (5123:2-9-18) D. Money Management (5123-9-20) E. Informal Respite (5123-9-21) F. HPC Transportation (5123-9-24) G. HPC (5123-9-30, 5123-9-31, and 5123-9-32) H. Shared Living (5123:2-9-33) I. Waiver Nursing Delegation (5123:2-9-37) J. Waiver Nursing (5123:2-9-39)			
2. Medication Administration Records (MAR) and Treatment Administration Records (TAR) for the months requested for individuals in the sample who receive medication administration and/or treatments			
3. Current physician's orders for individuals in the sample who receive medication administration			
4. Waiver Nursing services documentation (*if applicable)*: A. Individual record/Plan of Care (485) with required elements B. Clinical notes or progress notes C. Documentation of face to face visits			
5. For providers of employment services, evidence that a written progress report was submitted to the individual's team at least annually			
SECTION 6: MUI/UI	**YES**	**NO**	**N/A**
1. MUI and UI reports for the 12 months prior to the review date, including notifications and follow-up on incident. Please be prepared to pull incident reports as requested by the reviewer			
2. If no incidents have occurred within 12 months prior to the review date, please provide a template of an incident report to be used in the event of an incident			
3. UI Log(s) and evidence of monthly UI reviews for the months requested, even if no incidents occurred			
4. Most recent MUI Annual Analysis/Summary and evidence that it was sent to the County Board			
SECTION 7: PERSONNEL and POLICY	**YES**	**NO**	**N/A**
1. Evidence of CPR and First Aid certification.			
2. Evidence of appropriate licenses/certifications *if applicable* (i.e., nursing, OT/PT, etc.)			
3. Evidence of appropriate certifications if the staff person administers medication, insulin injections, G tube, J tube, or performs health related activities, *if applicable*			
4. Evidence of training for vagus nerve stimulator, epinephrine auto-injector and/or administration of topical over-the-counter medication for the purpose of cleaning, protecting, or comforting the skin, hair, nails, teeth, or oral surface, *if applicable*			

INDEPENDENT PROVIDER
REQUIRED DOCUMENTS LIST

5. For providers that transport individuals, please provide the following: A. Evidence of valid driver's license B. Evidence of current insurance policy for vehicles that are used to transport individuals			
6. Evidence that provider met with a representative of the county board prior to providing services.			
7. Evidence of training on service documentation and billing for services			
8. Evidence of annual training for the previous calendar year on the following, *if applicable*: A. MUI/UI requirements and health and welfare alerts from the previous year B. Rights of individuals with DD C. Person-centered planning, community integration, self-determination, and self-advocacy			
9. Evidence that the provider received training specific to each individual he/she supports prior to providing direct services			
10. For the Money Management waiver service, evidence of 8 hours of annual training on topics that enhance skills and competency relevant to providing money management			
11. For Career Planning or Individual Employment Support providers, for the previous calendar year, *if applicable* on the following: A. MUI/UI requirements and health and welfare alerts from the previous year B. Rights of individuals with DD C. Person-centered planning, community integration, self-determination, and self-advocacy D. Role in providing behavioral supports to individuals served E. Best practices related to the provision of the specific waiver service			
SECTION 8: TRANSPORTATION *if applicable*	**YES**	**NO**	**N/A**
1. Evidence of daily pre-trip inspections for the months requested above for Non-Medical Transportation in a modified vehicle or a vehicle equipped to transport five or more passengers.			
2. Evidence of daily pre-trip inspections for the months requested above for routine transportation in a modified vehicle.			
3. Evidence of current annual vehicle inspection for Non-Medical Transportation in a modified vehicle or a vehicle equipped to transport five or more passengers.			
SECTION 9: Physical Environment *if applicable*	**YES**	**NO**	**N/A**
1. Residence or other enforceable lease agreement (with guardian addendum, *if applicable*) in provider owned or controlled settings (including shared living)			

OHIO DEPARTMENT OF DEVELOPMENTAL DISABILITIES

PROFESSIONAL SERVICE AND FOLLOW-UP

To be completed prior to visit:

Name _____ **Date** _____ **Accompanied By** _____

Treating Professional (Doctor)/Title _____ **Phone #** _____

Reason(s) for the visit:

☐ Acute Illness ☐ Eye Exam ☐ Therapy (type) _____
☐ Follow Up ☐ Gyn. Exam ☐ Lab Work (specify) _____
☐ Initial Consultation ☐ Annual Physical ☐ Diagnostic (specify) _____
☐ Acute Injury ☐ Dental Exam/Cleaning ☐ Mental Health/Behavior
☐ Other _____

Symptoms (severity, frequency, duration) _____
_____

Questions _____

Pertinent Attached Information: ☐ Medication List ☐ Current Personal Summary
☐ Consults ☐ Labs ☐ Diagnostics ☐ Other _____

To be completed by TREATING PROFESSIONAL:

Diagnosis _____

Progress Note _____

Treatment Provided _____
_____
_____
_____

New/Changed Medication(s) – Name/Amount/Frequency/Duration_____
_____
_____
_____

FOLLOW UP INSTRUCTIONS/ORDERS _____
_____
_____

Restrictions for Activities/Work _____
Diagnostics _____
Labs _____
Diet _____ Therapy _____

Return Visit Needed? ☐ Yes ☐ No If so, when: _____

If no improvement in _____ days: ☐ Return to office ☐ Call doctor's office/doctor
If worsening: ☐ Return to office ☐ Call doctor's office/doctor

Signature of Treating Professional: _____Date:_____

HEALTH PROFESSIONAL APPOINTMENT LOG

NAME: Date of Birth:	Guardian ("G"): Phone # : Under what conditions does the guardian want to be notified:

DUE DATE	SCHEDULED DATE	REASON FOR THE VISIT OR PRESENTING PROBLEM	NAME OF TREATING PHYSICIAN/DENTIST/LAB X-RAY/PROFESSIONAL/THERAPIST	OUTCOME OF THE VISIT (see key below)				REFERRAL OR FOLLOW UP INFORMATION	"G" CALLED Yes or No

KEY: Outcome of the Visit "I" – Initial Visit "Res"-Condition Resolved "Ref"-Referral Made "Ret"-Return Visit

From the Clearwater COG Provider Resources website: https://clearwatercog.org/resources-provider/

MONTHLY INDIVIDUAL FUNDS TRANSACTION RECORD

INDIVIDUAL'S NAME: _____ MONTH/YEAR: _____

Date	Description of Transaction	Ref. No	Debit (-)	Credit (+)	Balance	Individual's Signature	Staff Signature
			Beginning Balance				
			Ending Balance				

Reviewer's Signature _____ Date _____

Note: Reconciliation of the Transactions Record should be done no later than 60 days, from the date of the first entry

A receipt for each transaction must be attached

Updated 4/2017

Cash Reconciliation Form

Individual Name: _____ Month/Year _____

End Balance from previous month: _____

Plus total deposits (+) _____

Subtotal: _____

Less Debits: (-) _____

Adjusted ending balance: _____

Adjusted ending balance shown above should agree with the ending balance on the ledger **

Be sure the individual signed or marked acknowledging receipt of any personal spending funds, which the person is entitled to and able to spend without receipts per the individual service plan.

A person other than the one who provides direct assistance to an individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider must conduct the reconciliations of accounts. See rule **5123:2-2-07 Personal funds of the individual**

Person reconciling account (Print) _____

Signature of person reconciling account: _____ **Date:** _____

Individual Gift Card Ledger

Individual's Name: _____ Month/Year _____

Provider: _____ Individual Signature _____

ATTACH RECEIPTS FOR ALL GIFT CARD EXPENDITURES.

Balance brought forward $ _____

Date	Transaction Description	Deposit	Withdraw	Receipt #	Balance	Staff initials
	Amount Carried Forward					

Staff Signature: _____

Person Reconciling Signature: _____ Reconciled/Verified Date: _____

Please remember that someone other than the person handling the gift card will need to reconcile the ledger once every thirty days.

2/8/17

From the Clearwater COG Provider Resources website: https://clearwatercog.org/resources-provider/

Gift Card/Certificate Reconciliation Form

Individual Name: _____ Month/Year _____

End Balance from previous month: _____

Plus total deposits (+) _____

Subtotal: _____

Less Debits: (-) _____

Adjusted ending balance: _____

Adjusted ending balance shown above should agree with the ending balance on the ledger **

Be sure the individual signed or marked acknowledging receipt of any personal spending funds, which the person is entitled to and able to spend without receipts per the individual service plan.

A person other than the one who provides direct assistance to an individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider must conduct the reconciliations of accounts. See rule **5123:2-2-07 Personal funds of the individual**

Person reconciling account (Print) _____

Signature of person reconciling account: _____ **Date:** _____

Checking Ledger

Individual Name: _____ Month/Year: _____

Page _____ of _____

Date	Num	Payee/Description	Catergory	Cleared	Debit (-)	Credit (+)	Balance
		Starting Balance					
						Total:	

Signature of person responsible: _____ Date _____

Signature of person reconciling: _____ Date _____

Savings Ledger

Individual Name: _____ Month/Year: _____

Page _____ of _____

Date	Num	Payee/Description	Catergory	Cleared	Debit (-)	Credit (+)	Balance
		Starting Balance					
						Total:	

Signature of person responsible: _____ Date _____

Signature of person reconciling: _____ Date _____

Reconciliation Form

Individual Name: _____ Month/Year _____

Outstanding Charges/Deposits

Check #	Debits (-)	Credits (+)
Total:		

End Balance on Bank statement: _____

Plus Deposits not shown: (+) _____

Subtotal: _____

Less Debits (-) not shown: (-) _____

Adjusted ending balance: _____

Adjusted ending balance shown above should agree with the balance shown in the check book. **

Be sure to deduct any charges, fees or withdrawals shown on the statement, but not in the checkbook that may apply to the account. Also, be sure to add deposits, interest accruals, shown on the statement, but not in the check book that apply to the account.

A person other than the one who provides direct assistance to an individual with managing personal funds or the one who maintains the written or electronic system of accounting for the provider must conduct the reconciliations of accounts. See rule **5123:2-2-07 Personal funds of the individual**

Person reconciling account (Print) _____

Signature of person reconciling account: **Date:** _____

Individual Food Stamp Ledger

Individual's Name: _____ Month/Year _____

Provider: _____ Individual Signature _____

ATTACH RECEIPTS FOR ALL FOOD STAMP EXPENDITURES.

Balance brought forward $ _____

Date	Transaction Description	Deposit	Withdraw	Receipt #	Balance	Staff initials
	Amount Carried Forward					

Staff Signature: _____

Person Reconciling Signature: _____ Reconciled/Verified Date: _____

Please remember that someone other than the person handling the food stamps will need to reconcile the ledger once every thirty days.

2/8/17

From the Clearwater COG Provider Resources website: https://clearwatercog.org/resources-provider/

TIPS FOR FINANCIAL DOCUMENTATION
GUIDELINES TO REMEMBER WHEN HANDLING A PERSON'S FINANCES

All accounts, which include: checking, savings, credit and/or debit cards, food stamps and gift cards, MUST be accounted for through the use of a "ledger" or "log." Everything is to be documented on the ledger as it takes place. For example when cash is taken out for a person to go out to dinner, the amount taken out should be documented on the ledger when it is taken out. The return of any change and the amount spent should be a second documentation notation.

Tips/Guidelines for using the ledger:

1. Keep a separate page for each month
2. Include type of account (checking. savings, etc.)
3. Include person's name
4. Date each transaction and enter on ledger in order by date
5. Number all receipts and put corresponding number on receipt
6. Include all receipts – for purchases of any kind; bank withdrawal/deposits; spending money to person signed by the person and staff giving money to the person
7. Write or print **LEGIBLY**
8. No checks written to "CASH", staff or another person (individual in the program)
9. **EXPLAIN RIGHT ON THE LEDGER** any differences, discrepancies, or questionable transactions
10. Double check math on all transactions; if there is a discrepancy between the actual cash-on-hand and the amount there should be, document. Ask for help to resolve if necessary. **NEVER ADD CASH OR TAKE CASH OUT** of cash-on-hand to make it balance. **ASK FOR HELP TO RESOLVE**.
11. Actual account balance of cash-on-hand should **ALWAYS** match actual amount of cash-on-hand
12. Count cash-on-hand together at shift change, daily
13. ALL transactions, incoming and outgoing are to be documented and initialed, legibly by staff completing the transaction.
14. Incoming funds – document the source, date and amount.
15. Always include a beginning and end balance

The most important thing to keep in mind when handling a person's finances is that someone who is unfamiliar with the documentation should be able to come in and be able to understand how the person's money has been spent.